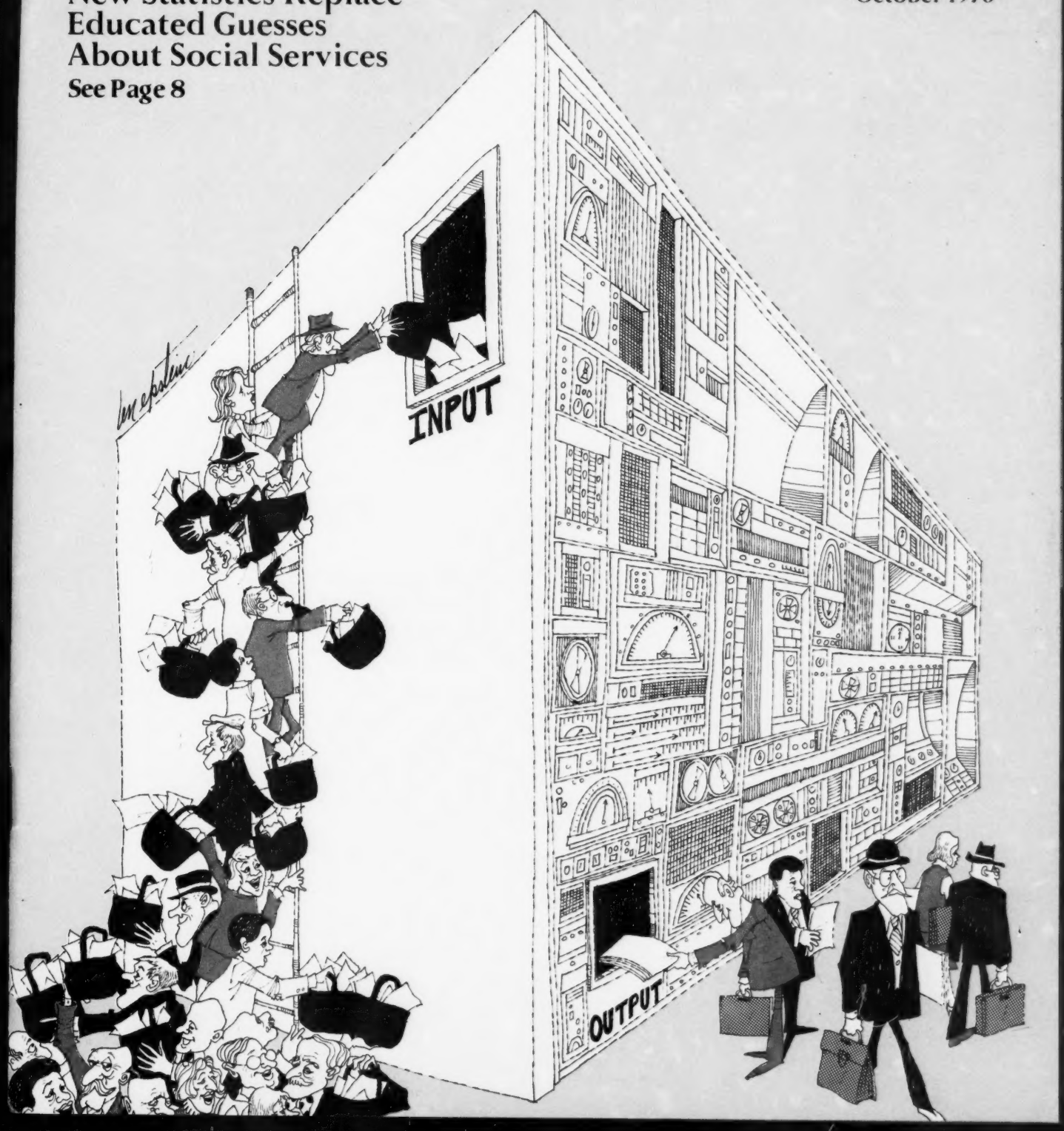
THE SOCIAL AND REHABILITATION
Record

Fighting Medicaid Fraud
Good Health for Rural Kids
Subsidized Adoption Program

October 1976

New Statistics Replace Educated Guesses About Social Services

See Page 8



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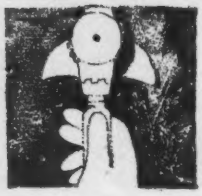

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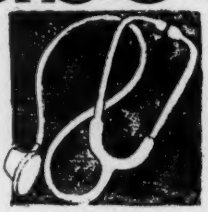

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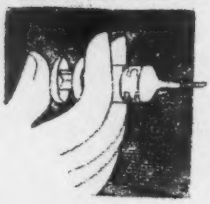

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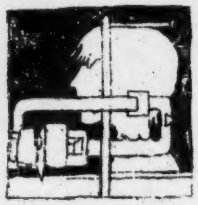

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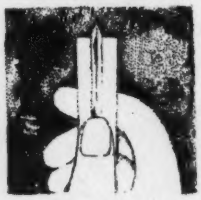

And charted.

And treated.

Preventive health services are important to vulnerable children . . . especially those from poor families, who have 3 times as much heart disease, 7 times the visual impairment, 6 times the hearing defects, and 5 times the mental illnesses. That's why there is an EPSDT program . . . Early and Periodic Screening, Diagnosis, & Treatment. Children in Medicaid families qualify for EPSDT.

For more information, see your local health or welfare office or write Commissioner, Medical Services Administration, Washington, D.C. 20201.

THE SOCIAL AND REHABILITATION
Record
Volume 3 • Number 6 • October 1976

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The Social and Rehabilitation Record is the official periodical of the Social and Rehabilitation Service of HEW. It is published 10 times a year by the SRS Office of Public Affairs. *The Record* is designed to provide information that will help professionals in State and local agencies and private organizations do a more effective job of carrying out programs which help people in need. The programs include social services for families and individuals, medical services, and assistance payments. Annual subscriptions are $6.40 (domestic) and $8 (foreign) and are paid to the Superintendent of Documents, P.O. Box 1533, Washington, D.C. 20402. Address manuscripts and article ideas to the Editor, Rm. 5327 MES Building, SRS HEW, Washington, D.C. 20201. Telephone 202-245-2196. Publication funds were approved by the Office of Management and Budget on February 25, 1972, amended December 4, 1973.

The opinions expressed in this magazine do not necessarily reflect the views and opinions of SRS or HEW.

For the Record

The medical profession has been taking it on the chin in recent months as one after another of its members have been hauled into court and convicted of fraud in their Medicaid practices.

No one condones such illegal practice, but, while some simply stand by with a tisk-tisk attitude, others, such as the Massachusetts Medical Society, are trying to do something about it. Since 1968 the society has been tightening its own standards of performance for physicians.

One of those who helped set the standards and write the stringent system of review for physicians suspected of improper practices is Dr. Louis Alfano, a former president of the society.

The Record talked with Dr. Alfano recently about the success of the society and the techniques it uses to identify physicians who try to beat the system.

Dr. Alfano feels that the percentage of "bad apples" is small, perhaps as little as one half of one percent. But the fact that it exists at all is reason enough for the society to spend a significant amount of time and money on a system to curb the abuse.

The story of how the society has policed itself begins on page three.

Two other articles in this issue also deal with physicians. One is about two young doctors in New York who are volunteering their time and skills to provide health care for children in a city day care center.

The other article is written by Dr. Albert May, a pediatrician in rural Ohio, who became aware of the medical deprivation which can occur in a rural area. It shows how community cooperation and innovation made the EPSDT program work in this area.

Martin Judge

Medicaid Fraud and Abuse Fought by State Medical Society

The Massachusetts Medical Society has been a leader in policing its own profession for Medicaid fraud and abuse since 1968. Six months ago the society intensified its effort to identify physicians who perform "unnecessary surgery or other inappropriate medical care" by establishing a separate committee of review. To be sure the project got off to a fast start the society voted $50,000 to implement it. None was more pleased with this escalation of policing activity than its then president, Dr. Louis F. Alfano, who has been an outspoken and innovative advocate of peer review for many years.

THE RECORD: Dr. Alfano, you have said there are "pockets of pestilence" in the medical profession, and that everything possible must be done to eradicate them. How do you go about that?

DR. ALFANO: Well, there are many ways. First we look at the high users of Medicaid. If someone collects a greater percentage than his peers, he is a prime target and his claim forms are examined. An examiner goes to doctor's office and checks his records of Medicaid patients.

Our society's Committee on Ethics and Discipline received 44 complaints against doctors during the entire year of 1972. Last week our board met and in one day they examined 44 cases. One reason for this is the society's information referral service which allows a citizen of the commonwealth who doesn't have a doctor to call the State society on a free WATS line and receive the names of three competent physicians to choose from. That's one part of the system.

The other part of the system is that we are constantly asking the public to report a doctor who is not performing up to standards. When a complaint is received it is investigated and the complainant receives an answer.

THE RECORD: Can you give some examples of how physicians abuse the Medicaid program?

DR. ALFANO: Very often this takes the form of overstating the complexity of the treatment. Oh, such as knocking off a few pimples and invoicing for I&Ds, that is making incisions in large abscesses and draining them. That's a difference in billing of $40 or $50 for the I&Ds compared with no charge for the pimples.

Another technique is simply saying they performed procedures that they never did. For instance, a patient comes in with a cold and the doctor writes it up as a suture of a laceration.

In one case four or five years ago, the Department of Public Welfare made an error and paid a doctor twice for an appendectomy. Well, the doctor identified that double payment as a flaw in the system and proceeded to send in duplicate or triplicate bills for the same case. It worked for a while but, of course, he was eventually trapped and admitted his guilt.

THE RECORD: What conditions encourage Medicaid abuse?

DR. ALFANO: An unsupervised situation. In hospitals work is pretty well supervised by our self regulatory system such as medical audits, surgical audits and peer review. Very few deviations from the norm are occurring now in the hospitals of Massachusetts.

The real abuse occurs in the physician's office. The only way we are going to attack this problem in the office is through the evolution of the different health care foundations in which peer groups in each specialty review cases. If a doctor is performing, say, 2,000 I&Ds and all other surgeons in the State combined don't do 1,000, you know something is wrong when you compute it.

THE RECORD: How widespread do you think the Medicaid abuse is in Massachusetts and in the country?

DR. ALFANO: That's hard to say, but it is not as high as what one might gather from the news media. For instance, we have over 12,500 doctors here and you are talking 50, 60, 100 or perhaps 200 of them are involved in fraud and abuse—a very small percentage.

THE RECORD: How are the Professional Standards Review Organizations progressing in Massachusetts?

DR. ALFANO: Right now PSROs are used to determine medical necessity and proper length of stay within the hospital environment. At this time they are not involved in work performed out of the hospital. The foundations take care of that work. Our peer review group, the Bay State Health Care Foundation, has a contract with Blue Shield. So when the Blue Shield staff finds that someone has deviated from the norm they turn it over to the foundation. The foundation convenes a peer group and they go over all the cases. They have the doctor in to explain his type of practice and then he is told that it is not medically acceptable.

THE RECORD: But sometimes you read about a physician being sacked in, say, New York and then setting up practice in a city 1,000 miles away without being challenged for his past misdeeds.

DR. ALFANO: Unfortunately, that's true. In fact, very often the doctor doesn't have to move out of

"If someone collects a greater percentage than his peers, he is a prime target and his claim forms are examined. An examiner goes to the doctor's office and checks his records of Medicaid patients."

"We are constantly asking the public to report a doctor who is not performing up to standards. When a complaint is received it is investigated and the complainant receives an answer."

town. Due to a lack of communication a doctor can be thrown off the staff of one hospital in a big city like New York for being incompetent, or for something else. He can then walk three blocks to another hospital and immediately get staff privileges.

The AMA is currently developing information systems so that no matter where a doctor goes his record will follow him.

THE RECORD: How soon will this procedure be put into effect?

DR. ALFANO: At this point the Federation of State Medical Boards, the AMA, the State medical societies and the State boards of registration are compiling lists of doctors who lose their licenses and why.

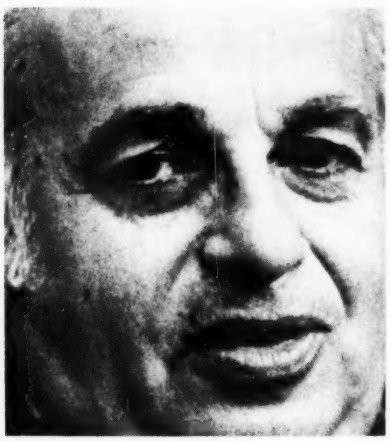
In Massachusetts the medical society publishes the names of doctors whose licenses are revoked in our professional newsletter and we see to it that the news media is notified. In 1975 the media listed the names and addresses of the seven doctors who lost their licenses and the reason they were lost.

THE RECORD: What do you think will be the long-run effect of publicizing these cases?

DR. ALFANO: The medical profession has been very, very hesitant about revealing cases like this until it gets to a State board. If it gets into the press prematurely then the whole profession is tarnished by a few bad apples.

But the way it is set up in this State, there is full disclosure once a charge against a doctor comes before the Board of Registration and Discipline in Medicine. At that point there is an open hearing—open to the general public and press. Full disclosure is no problem because it is a public forum.

THE RECORD: What form does



"The real abuse occurs in the physician's office. The only way we are going to attack this problem in the office is through the evolution of the different health care foundations in which peer groups in each specialty review cases."

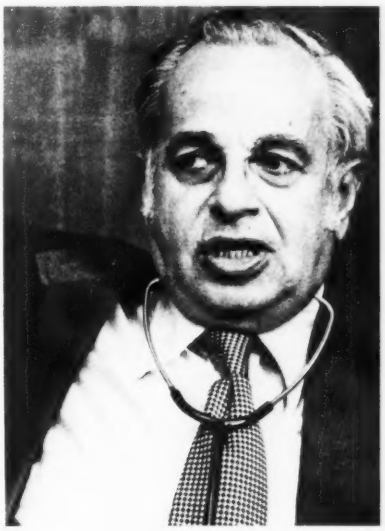
the investigation of a physician take?

DR. ALFANO: It is a cooperative effort between the Massachusetts Medical Society, the Department of HEW and the State Department of Public Welfare. The process is a very simple process. When the Massachusetts Department of Public Welfare finds a deviation from the norm it conducts an investigation. After the due process of the judicial system is concluded, the case goes to our Medical Society. First the society's Committee on Ethics and Discipline reviews the case to see if there is probable cause. This is like a grand jury proceeding. If the fellow is found guilty he is notified of the findings. Then he has the right of appeal up to the society's Judicial Committee where he can be represented by a lawyer and bring in evidence with which to defend himself. The Judicial Committee can reverse the findings of the Committee on Ethics and Discipline. Of course, if the Judicial Committee finds that the fellow is guilty as charged, they automatically send it to the State Board of Registration and Discipline in Medicine for revocation or suspension of the license. So you see it would be pretty hard for a doctor to accuse anybody of railroading him. The due process is there and all evidence is submitted on both sides.

THE RECORD: How have the physicians in Massachusetts accepted this self-policing policy?

DR. ALFANO: The physicians are for that process 100 percent when it is explained. It is a matter of showing them that confidentiality of the patient and the innocent doctor would be upheld, and that there would be due process. As long as you can satisfy those three areas of concern, the doctors will cooperate 100 percent.

"Due to a lack of communication a doctor can be thrown off the staff of one hospital in a big city . . . then walk three blocks to another hospital and immediately get staff privileges."



"We have over 12,500 doctors here and you are talking . . . of perhaps 200 of them involved in fraud and abuse—a very small percentage."

THE RECORD: Should there be a Federal law requiring every State society to vigorously police itself?

DR. ALFANO: Federal regulations require that States establish methods for identifying potential fraud and abuse as well as methods of investigation and referral of such cases. The Federal Government should also become more involved in establishing national minimal standards.

THE RECORD: How can we devise a better way of controlling Medicaid costs?

DR. ALFANO: I feel very strongly that the Medicare program is working relatively well. I think that if the same type of fee structure we have for Medicare were applied to Medicaid we would be a lot better off. Since Medicaid is being administered by State agencies, you are dealing with the State legislatures. This is what really upsets the whole works. I think if you had the same type of supervision and payment of fees as you do under the Medicare program, we could really get somewhere.

THE RECORD: Are most of the complaints from individuals or other sources?

DR. ALFANO: They come from all quarters—the general public, hospitals, other doctors, insurance companies and from government agencies.

Other times, illegal practices are discovered when a patient asks a third party or Medicaid how a doctor got $100 and all he did was a routine examination for a cold.

THE RECORD: Would one substantiated complaint be enough to revoke a physician's license?

"In Massachusetts the medical society publishes the names of doctors whose licenses are revoked in our professional newsletter and we see to it that the news media is notified."

"I think that if the same type of fee structure we have for Medicare were applied to Medicaid we would be a lot better off."

DR. ALFANO: Yes, if an individual complaint was bad enough. If it were proven that a fellow was doing something that was not necessary, such as surgery, or something that was in violation of the State code, one complaint would be enough.

THE RECORD: Is it harder to discover improper actions under Medicaid than under, say, Blue Cross and Blue Shield?

DR. ALFANO: It is a lot easier for us under Blue Shield because it has a contract with the five health care foundations in the State. Because of this, we have the medical manpower to examine thousands of claims.

You see, the Medicare program is handled by Blue Shield in this State. The peer review by the foundation is also applied to Medicaid beneficiaries at the same time.

THE RECORD: When did the Medicaid policing effort begin?

DR. ALFANO: The Medicaid effort started in 1968 when the Public Welfare Department and the Massachusetts Medical Society began cooperating. We had a very good relationship with the Welfare Department, although this relationship has been virtually destroyed by our State legislature by not voting sufficient funds for the Welfare Department. This last year they cut 30 percent off the fee schedule that was the fee schedule in the 50th percentile of 1970 fees. So when you ask doctors to do peer review for a welfare program and the legislature has cut funds from the welfare program, you can't blame the doctors from wanting nothing to do with it.

THE RECORD: Where do you feel that Massachusetts ranks in relation to the other States in stopping fraud? Is it pretty much at the forefront?

DR. ALFANO: I feel Massachusetts is more advanced in its peer review capabilities than many States. That's because of this very unique cooperation between the State Medical Society and between the foundations and Blue Shield. However, in areas other than peer review, Massachusetts has room for improvement.

THE RECORD: If other States wanted to institute a more stringent self-policing program what would be your recommendations based on your experience?

DR. ALFANO: Well, the important thing is to use the computer capabilities of the regulatory agencies or the Blues to sift out those who deviate from the norm. Then those cases should be given to a peer group made up of either members of the State medical society or members of local foundations.

THE RECORD: You have said on a number of occasions that it is extremely important for physicians to police themselves. Why is this so important?

DR. ALFANO: Well, because they are the only ones that can really ascertain whether or not the doctor performed in response to a medical necessity.

An idea we are now promoting in Massachusetts is that a doctor is guilty of unethical practice if he fails to report another doctor who he discovers doing something illegal or performing some medically unaccepted procedure. This is something that we have to promote. We have to get these people either rehabilitated or get them out of the system.

THE RECORD: It seems strange that members of such an ethical profession are involved in fraudulent practices?

DR. ALFANO: That's true, but doctors are human beings. A man can create a lock that is foolproof, but there is always someone with a little larceny-in his heart who will figure a way to pick the lock.

HOW TO

Do a Better Job of Managing the AFDC Program

The Assistance Payments Administration of HEW's Social and Rehabilitation Service is acting as a clearing house for reporting on ways in which States have moved to improve management of their Aid to Families with Dependent Children (AFDC) programs. A number of these "How They Do It" reports now have been published and are available without charge.

"How They Do It" publications include:

Managing the Intake Process in Income Maintenance—*Minnesota, Washington.*

Photo I.D.s—*New York.*

Supervisory Review of Case Actions—*New Mexico.*

Work Measurements and Workload Standards as Management Tools for Public Welfare—*Michigan.*

Child Support Payments Control—*Massachusetts and Washington Bank*

Distribution (of Assistance checks)—*Pennsylvania and Nassau County.*

State Monitoring of Local Office Performance—*Maine, Washington.*

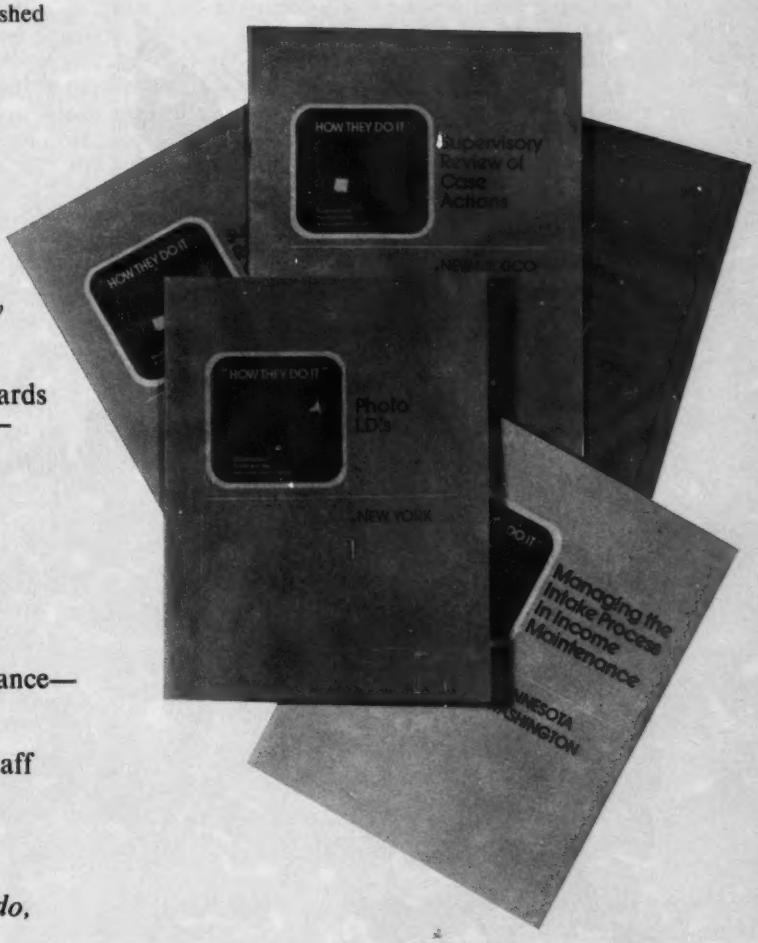
Managing a State Income Maintenance Staff Training Program—*Florida, Texas.*

Fraud Control—*California, New York.*

Wage Record Clearance Systems—*Colorado, Oklahoma.*

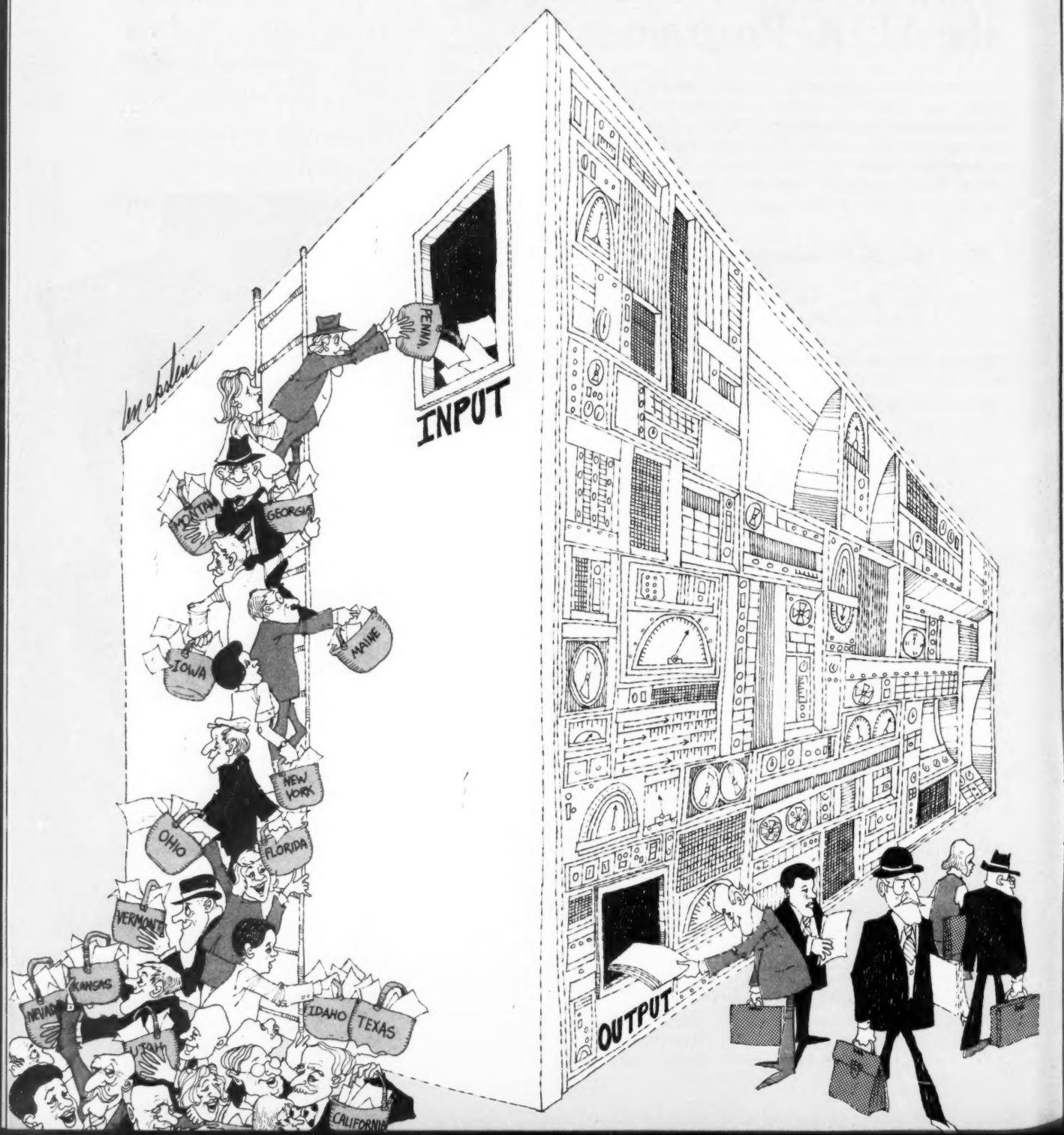
Recipient Response Forms Utilized in AFDC—*Selected States.*

Improving AFDC Operations Through Management Controls and Use of Error Profiles—*West Virginia.*


HOW THEY DO IT
Supervisory Review of Case Actions
HOW THEY DO IT
HOW THEY DO IT
Photo I.D.'s
NEW YORK
Managing the Intake Process in Income Maintenance

For copies, write:

Assistance Payments Administration
State Systems Management Division
Social and Rehabilitation Service, DHEW
Room 1232-B
330 C Street, SW
Washington, D.C. 20201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OUTPUT

New Statistics Replace Educated Guesses about Social Services

Planning social services programs and budgets took a great step forward this month with publication of the first in a series of national reports showing what services the various States are providing to whom.

According to the report more than 2.6 million children and adults received social services during the quarter ending December 31, 1975.

The services covered by this report include: the Title XX Social Services Program, the Title IV-B Child Welfare Services Program, and WIN, the Work Incentive Program operated jointly by HEW and the Department of Labor.

A major question answered by this report, titled *Social Services U.S.A. Oct. - Dec. 1975,* is the percentage of persons in seven categories who receive one or more services. They are: Aid to Families with Dependent Children, 40 percent; those eligible to receive assistance due to their income level (Income Eligibles), 19 percent; those who are aged, blind or disabled and eligible for Supplemental Security Income (SSI), 17 percent; those eligible to receive protective services without regard to their income, nine percent; Work Incentive Program, six percent; Medicaid, four percent; and Child Welfare Services, four percent.

While most of the statistics were reasonably consistent with previous educated guesses, there were a few surprises. One was that more than 1,000,000 children are directly receiving some type of service.

The report also documented that about 20 percent of recipients receiving AFDC social services discontinued these services during the quarter studied.

SRS Administrator Robert Fulton cautions that "due to the complexity of this reporting system, the first report is somewhat incomplete. But," he says, "we are refining our information system on social services, and subsequent reports will yield additional information."

Of course, the greatest benefit of the reports is that they will permit SRS and State and local agencies to know how many recipients receive what services and at what cost. SRS currently spends about $2.4 billion annually on these programs. The Federal Government pays 75 percent of the program costs in most cases.

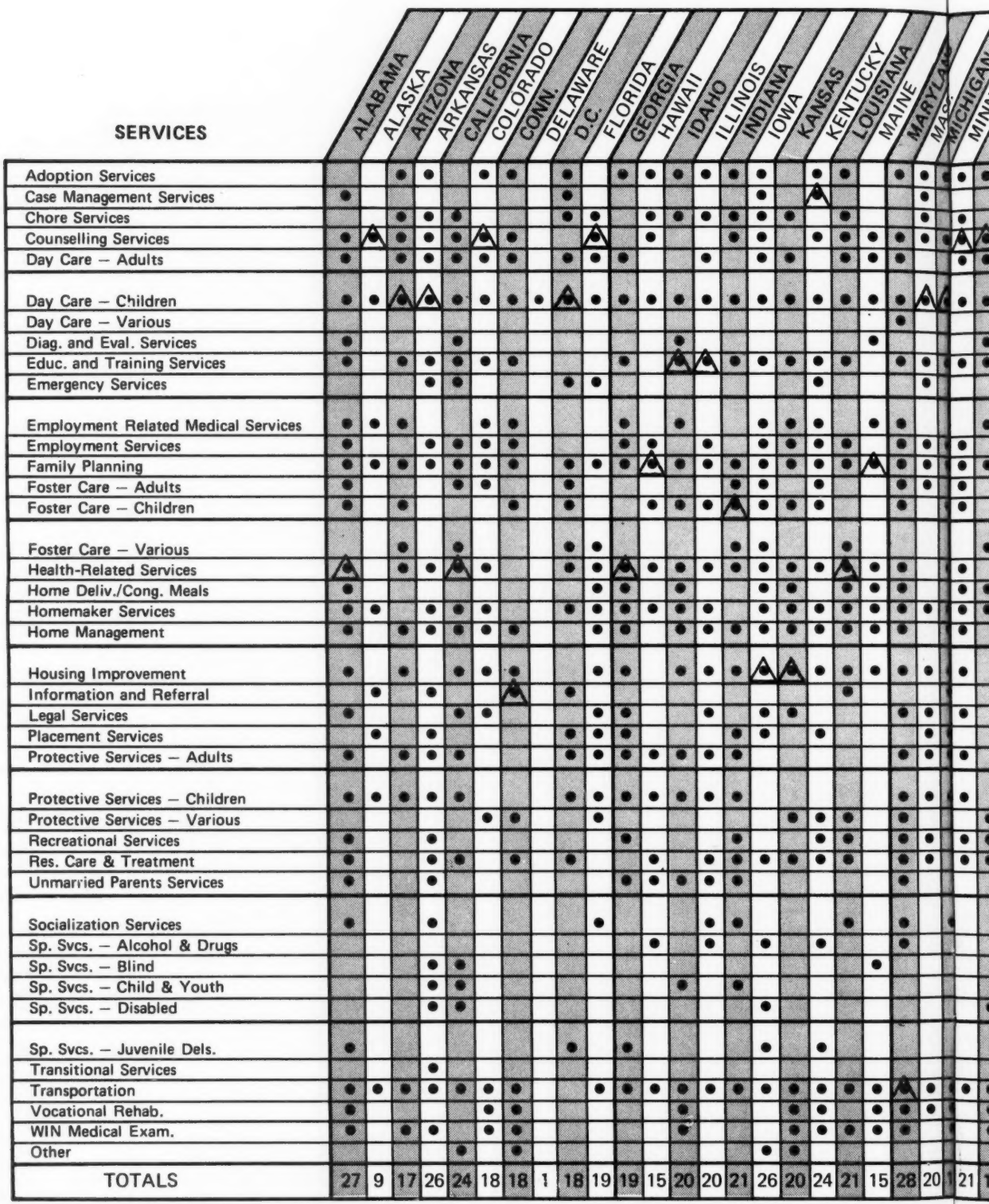
Even though the States are virtually free to determine what services they offer, the diversity and number of different services (1,313) they reported were surprising. For the purpose of analysis and comparison, the services were grouped into 41 categories. A listing of the services offered by each State appears on the following pages.

Services provided most frequently were family planning, 49 States; child day care, 50 and the District of Columbia; transportation, 47; and health-related services, 43.

As data become available, future reports will present information on the cost of the services, the methods used to provide them, such as whether a State purchases them for the recipients or if the recipients purchase them. Also included will be the goal for which each service is rendered, such as self-support or protection.

Questions about *Social Services U.S.A.* should be addressed to the National Center for Social Statistics, Room 5329, SRS/HEW, Washington, D.C. 20402.

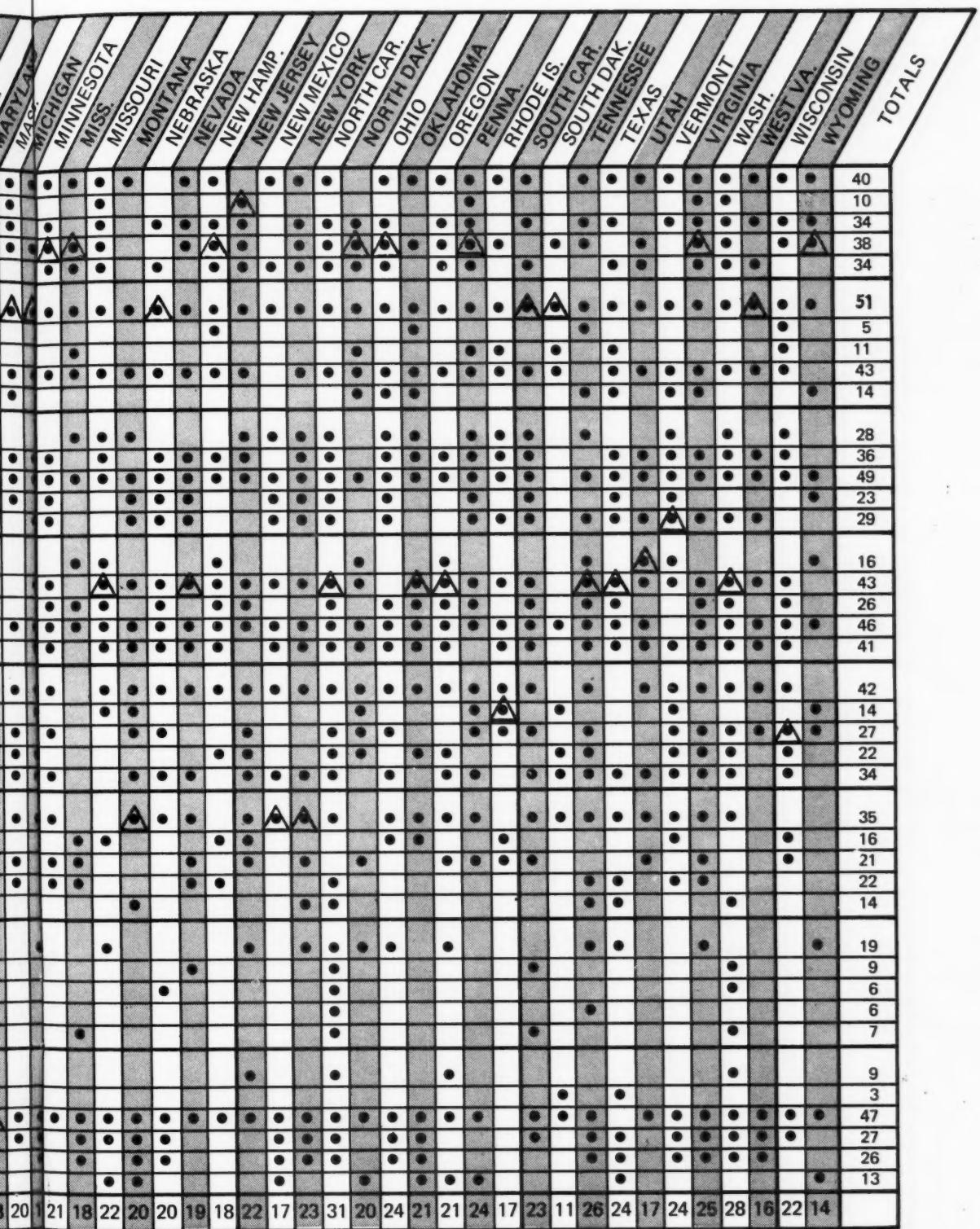
Services Delivered by Each State From Oc



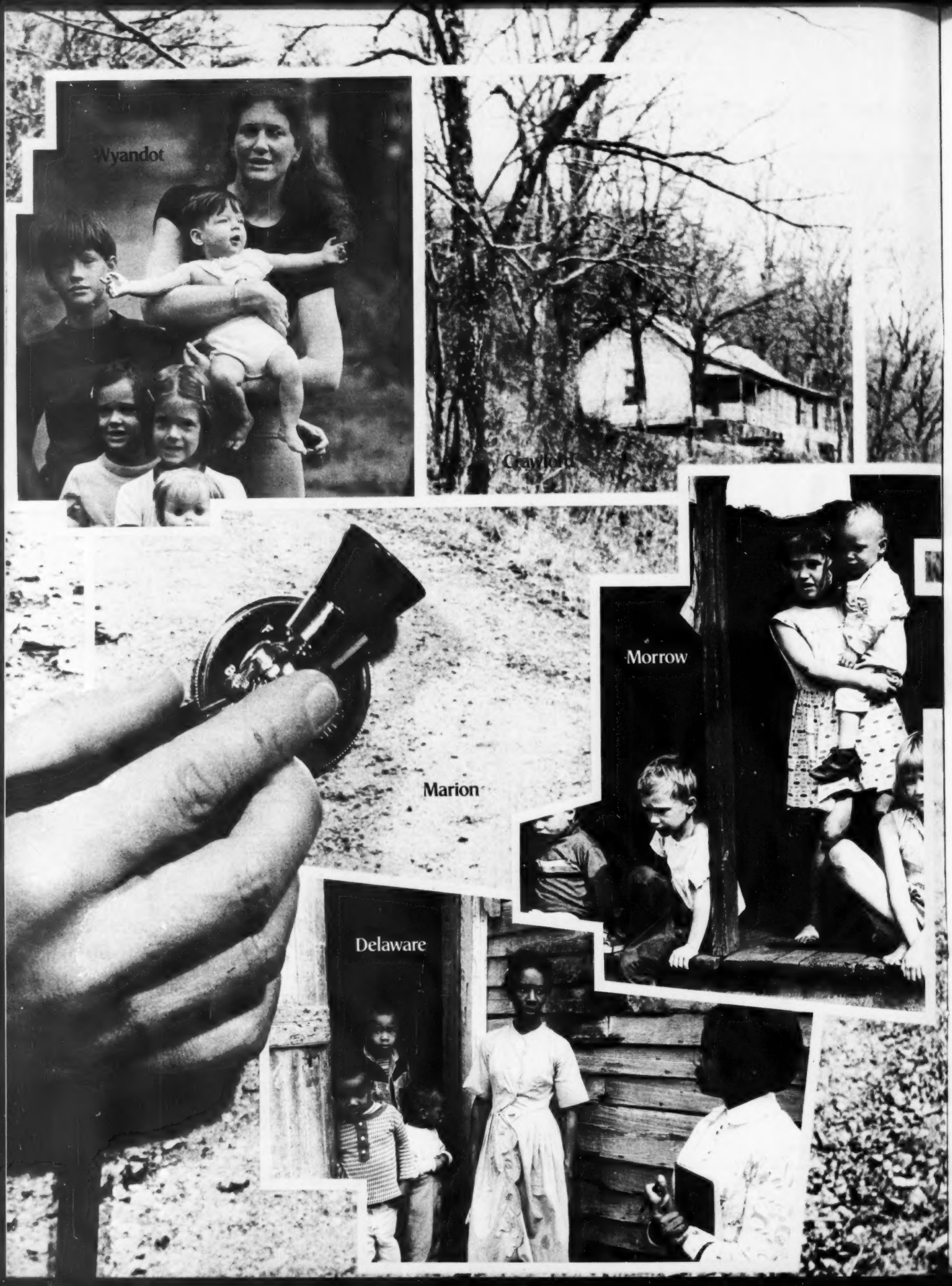
▲ Services most frequently delivered in the State

* Services were delivered to families and are not included in recipient counts

om October to December 31, 1975



Source: Based on expenditures reported and estimates of the resident civilian population as of January 1, 1974, by the Bureau of the Census.


Wyandot
Crawford
Morrow
Marion
Delaware

Good Health for Rural Kids

How community cooperation made EPSDT work in five rural Ohio counties.

By Dr. Albert May

Until we inaugurated the Early and Periodic Screening, Diagnosis and Treatment program in our area, most of us—physicians and community leaders—thought the rural poor were vastly better off than the poor in an urban environment. After all, rural families could always live off the land if their fortunes worsened. However, we learned that it is the rural poor who have greater problems. Unfortunately, this is also true when it comes to health care.

The main problem of this group is that it is so widely dispersed that the people are unable to organize and make requests of the community or even demonstrate their need. They are, in effect, politically invisible. And since they are, when there is community planning to be done no one thinks about their needs and no one plans services which include them.

The geographic dispersement of the children eligible for EPSDT made the prospect of delivering services to them a significant challenge. When our clinic, which is a private group practice, first learned of the EPSDT program back in 1974 there was substantial concern about whether it was a viable program for a rural situation like ours. We serve the five-county area of Crawford, Delaware, Morrow and Wyandot. We also thought that if it could work in our situation, it could work anywhere.

After learning about the program, our first step was for physicians at our clinic to discuss the problems that would have to be solved if we were to create an effective program. Our prime conclusion was that we could not implement the program by ourselves. Therefore we invited all agencies which were concerned with the welfare of children either partially or totally to a meeting on the EPSDT program. Representatives of 13 agencies from the five surrounding counties came. They included city and county health departments, the county welfare departments and school psychologists.

I should emphasize that without the cooperation of the entire community, we could not have achieved results that came anywhere close to what we did. And I should also emphasize that these people, though dedicated to their jobs, were not supermen, and did not work 12 hours a day to achieve these goals. This was a group of reasonable people pursuing a reasonable goal in a reasonable manner.

That meeting was the beginning of the program. The result of this cooperative effort and our own monitoring of patients after screening is that within six months after the first screening, 87 percent of the children requiring dental care are receiving it and 83 percent requiring further medical care are receiving it. This rivals the national average of about 85 percent of private pediatric patients who receive the care prescribed for them. These percentages are even more startling when you consider that only 10 percent of the children we treated were found to have ever had an on-going program of treatment. We also found the children, as a group, were substantially deficient in polio. (See chart on following page.)

Cooperative effort

At the first meeting I picked the name of a family eligible for EPSDT and asked the group how many of them had provided service to the family. Out of 18 persons there, seven hands went up.

It was immediately obvious that a number of efficiencies could be gained by coordinating our efforts. For one thing, it would be much more efficient for one agency to take the socio-medical history of a patient and make it available to the other agencies as needed. And quite aside from the question of efficiency, a comprehensive patient history would help us all do a better job for the patient.

Our committee designed a standard form for patient information, including environment and social history as well as medical history. It was decided that the family doctor would be the

Dr. Albert May specializes in pediatrics at the Fredrick C. Smith Clinic in Marion, Ohio, and is a clinical assistant professor in pediatrics and preventive medicine at Ohio State University College of Medicine.

Polio Update for 1,901 Children June 1974 - April 1976

Under age 2		
Inadequate Series	115	(53%)
Inadequate Booster	45	(20%)
Adequate	56	(25%)
No History	4	(2%)
Ages 2 to 5		
Inadequate Series	120	(27%)
Inadequate Booster	204	(45%)
Adequate	111	(24%)
No History	20	(4%)
Over Age 5		
Inadequate Series	39	(3%)
Inadequate Boosters #1	130	(10%)
Inadequate Booster #2	656	(54%)
Adequate	301	(25%)
No History	99	(8%)

Referrable Conditions Findings for 1,901 Children June 1974 - April 1976

Deficient Immunizations	1,527	(80%)
Dental Caries	1,416	(74%)
Acute Disease	315	(16%)
Learning Disabilities	354	(18%)
Abnormal Urinary Sediment	166	(8%)
Dermatoses	103	(5%)
Enuresis	86	(4%)
Eosinophilia	86	(4%)
Bronchial Asthma	29	(1)
Obesity	40	(2)
Oxyuriasis	18	(1)
Positive Histo Skin	37	(2)
Seizure State	33	(2)
Cephalagia	25	(1)
Beta Strep Pharyngitis	12	(1)
Anemia	52	(3)
Positive Tuberculin Skin	7	
Pregnancy	5	
Phimosis	12	(1)
Failure to Thrive	20	(1)
Bleeding	4	
Umbilical Hernia	4	
Developmental Retardation	20	(1)
Inguinal Hernia	5	
Corporal Hemihypertrophy	1	
Cerebral Palsy	3	
Diabetes Mellitus	1	
Suspected Goiter	3	
Post. Hypotension	1	
Referrals		
Ophthalmology	269	(14%)
Otolaryngology	58	(3%)
Orthopedics	35	(1%)
Public Health Nurse	26	(1%)
Gynecology	28	(1%)

team captain and his office would be in effect the library for the patient's file.

We established a system of interagency routing of information with attention to both the rights of confidentiality of the patient and his family as well as the health professional's need to have access to all pertinent data. We also developed a permit for the release of medical information.

Patient history

Since the doctors in our area were already overburdened with large practices, including care for the indigent, we felt that participation in the EPSDT program necessitated that most of the administrative work be done outside the doctors' offices. Therefore, under our program social workers from the welfare department visited the homes of those eligible for the program and took the socio-medical history of each patient. The same questions were also asked when the patient arrived at the clinic. This was done in order to ensure the accuracy of the information.

Even though our objective was to reduce work inside the clinic, we felt this double history was well worth the time, and we found that the quality of information which resulted was well worth the effort. We also found the time lapse from the social worker's home visit to the screening allowed the parents and, in some cases the children, to enlarge upon their answers about previous illnesses, etc., thereby giving us more precise information.

We did not use a preprinted history form where patients can check off appropriate answers because we had serious doubts about the value of this type of form.

As previously mentioned, the patient history included many questions about the patient's home environment including such things as indoor plumbing and exposure to industrial toxins. Such information is valuable in evaluation of childhood anemia. In cases where the caseworker found

obvious neglect, we asked for surveillance by the children's service agency.

A good social history can also save money by eliminating the need to perform unnecessary tests. It is my feeling for instance that a child living in a middle-class neighborhood does not require a lead screening examination—an examination which is rather expensive. If, on the other hand, the child lives in an older house where the paint is peeling, a lead test probably should be done as a matter of routine.

To keep costs down we employ paramedical personnel such as physician's assistants. Graduate physician's assistants are formally recognized by the State of Ohio to work under the direct supervision of doctors. Among their duties at our clinic are taking patient histories and performing routine examinations. Any suspicious finding in the history, examination or both is referred to the doctor.

In taking the patient histories, we encountered a substantial amount of hostility. Many families had an underlying hostility toward the establishment, believing that it is responsible in some way for their socioeconomic condition. Once this initial attitude was overcome, families were very eager to cooperate. Our approach for breaking the ice with these parents was to ignore the hostility and to stress what could be done for the child. We stressed the goal of normal growth and development for their children.

Scheduling appointments

Our program also was innovative in the manner of scheduling appointments. EPSDT clinics with fixed dates, times and locations had not worked well in other areas. Absenteeism exceeding 50 percent was the rule at the EPSDT clinic in Akron which had specific hours and days for appointments.

Our appointments were made by the welfare department, which also was responsible for insuring that appointments were kept. The welfare department would reconfirm appointments with the families just prior to the appointment. If fewer than 10 children could keep the group appointment, we canceled the clinic and rescheduled it for another day.

In this way our personnel costs were kept at a minimum. The maximum number of patients was set at 13; occasionally, in order that entire families might be seen together, more than 13 patients were scheduled.

Our staff had had considerable experience with indigent patients, but we were surprised to find that so few of these people had any concept of preventive medical care. Medical care was nearly always sought for children only on an emergency basis. An example of this was the response of a mother who had a son with epilepsy; if a seizure lasted more than five minutes, she sought emergency room help; if the seizure lasted less than five minutes, she did not.

Having the welfare department schedule appointments also verifies that the treatment received is credited to the right child. For instance, Mrs. Jones is scheduled to bring in her youngster for screening but can't find her Medicaid card; she wants to keep the appointment so she borrows Mrs. Smith's card and registers her son, Tom, as Tom Smith.

The result was a very accurate history of someone who will never benefit from it. In addition, significant problems arise under these circumstances in the reimbursement process. The local welfare office has the latest eligibility information, so it seemed logical for that agency to handle the majority of administrative work.

Philosophy of the Project

Proper health care for a child begins with the developing fetus and ends with the child entering adulthood. It encompasses a spectrum of activity ranging from treatment of acute illness to routine preventive medical practices such as immunizations, advice on nutrition and child-rearing. Proper health care is a job of continuous management, not one solely of reaction to crisis. Ideally, such a program should contain four characteristics. They are:

- Complete accessibility to care for the patients and their families.
- Continuity of care so both the child's psychological and physical needs are fulfilled, or at least not lost sight of.
- Coordination of all necessary services beyond the basic primary level of care, so that duplication is minimized.
- Community involvement in this program is the key to meeting all the needs of the patient. Next to patient and parent counseling, community educational programs on child health are given the highest priority.

Cutting red tape

Another timesaver was a billing form that we helped develop. Red tape in the reimbursement process is so notoriously tedious that when I spoke to an area dental society about cooperating in the EPSDT program, its reaction was less than enthusiastic. They wanted no part of the complicated billing system.

Fortunately, there was a great desire at the Federal and the State level to implement the program, so we worked together to streamline the billing procedure. The EPSDT invoice was pre-printed with each service and lab test likely to be performed along with their cost. Those services not performed were inked out on this invoice.

Transportation

Central to the problem of keeping appointments was arranging transportation. It was done in various ways, some of them quite innovative. I also think the ability to solve this

problem is indicative of the spirit in which the various agencies attacked the total problem.

There were no State guidelines about how to provide transportation. In one county, caseworkers used their own cars to bring children to the clinic. In another, where caseworkers would not do this, the city council was asked to appropriate funds so the program could lease city school buses.

Perhaps the most innovative solution of all was the county that bought a van and used funds from the Concentrated Employment Training Act to hire a person on welfare to drive it.

Referral and followup

Following the screening process, needed diagnostic tests or treatment is, at the family's choice, done either by the family doctor or the clinic. We do not refer directly to the family physician, but relay our findings and suggestions to the county welfare department. The department has a listing of doctors and agencies in the area, and can better coordinate the referral than can an individual clinic. The department knows which doctors have which type of practice in various communities and which are accepting EPSDT patients, so it is in the best position to make the referral and to provide follow-up services. In addition, this system also relieves us of a great deal of clerical work.

With this written notice to the welfare department our responsibility is discharged according to the EPSDT program guidelines. However, six months after the screening clinic, we write a follow-up letter to the county welfare department requesting updated information about the patients. It is this second letter that keeps everybody on his toes; nobody's file falls between the cracks — nobody is missed in the diagnosis and treatment process because he is forgotten.

The job ahead

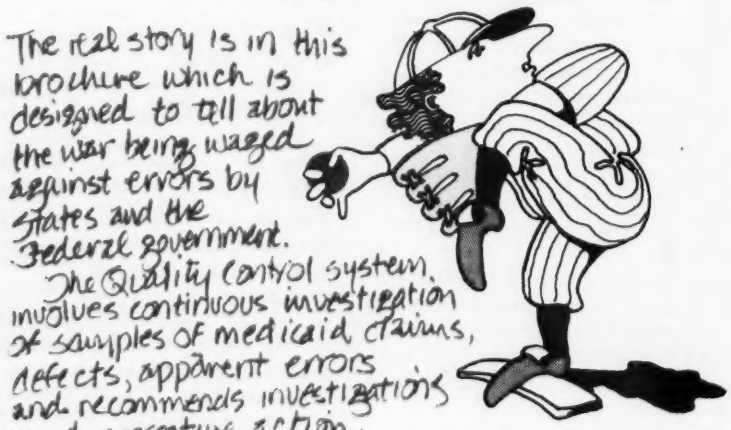
Despite the improved health enjoyed in the United States over the last several generations, it can be shown that among the poor proportionally more babies die, more children die and more mothers die in childbirth. Major medical advances have improved the lot of all, but not equally for all of our citizens.

In a large private pediatric practice, we found 85 percent of the children are adequately immunized for their age. And according to reports of the Ohio Department of Health 65 percent of all children are adequately immunized for their age when they enter the public school system. However, we find only 20 percent of all children receiving Aid to Families with Dependent Children are adequately immunized. A poor record indeed, and one of the areas which must be improved if we are to continue to hold that all children, regardless of the economic status of their families, shall have quality comprehensive health care.

As of September we had successfully screened 2,196 of the eligible children (see chart for referrable conditions) in our area and are actively following 1,013. The remainder are followed by their family physicians or cannot be located. Our challenge lies in the 20 percent of this group which, because of changing family fortunes, is lost to followup. Too often these families go from the assistance rolls to a level of barely-adequate subsistence where they are no longer eligible for EPSDT assistance and feel private medical care is not affordable.

At the present time, we have no realistic way of tracking the children of these marginal-income families to see how they fare. I suspect they fare poorly; but until such time that funds are generated to study them and what resources are available to treat them, I don't believe that we can accurately describe their problem. But whatever its magnitude, society will have to find workable solutions if we are all to reap the benefit of our most valuable resource — our children. ■

Are you accused of throwing money at the problem?


The real story is in this brochure which is designed to tell about the war being waged against errors by States and the Federal government.
The Quality control system involves continuous investigation of samples of medicaid claims, defects, apparent errors and recommends investigations and corrective action.

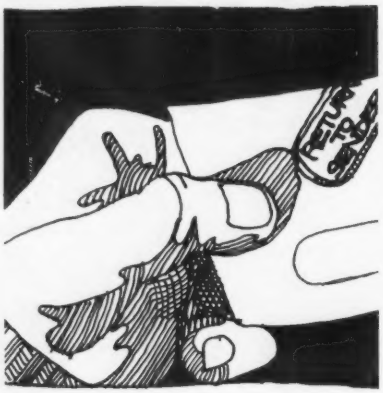
THE SOCIAL AND REHABILITATION **Record**

Quality Control in Aid to Families with Dependent Children is available without cost in bulk from the Social and Rehabilitation Service, Publications Distribution Office, Room G115-B, MES Building, SRS/HEW, Washington, D.C. 20201.

"Where Does My Money Go?"

Find out how to get your money together in your own budget. Find out how to keep track of where your money comes from and where it goes.
Check it out with your local social services agency.
(A "supportive service" under WIN)

For quantity reprints of this page, write Editor, *The Social and Rehabilitation Record*, Room 5327 MES Building, SRS, HEW, Washington, D.C. 20201



A new twist: money returned

"I am now back to work and pleased to return most of the last check," said a letter to the Governor of Maine. It was written by a welfare recipient who enclosed $223.

This self-employed carpenter was receiving AFDC because he had cut his hand and was unable to work. He returned about two-thirds of the $335 alotted his family of five. He also returned another check that had been mailed before the State received his letter.

Reform measures offered by welfare association

Following a year long study of income support programs and welfare reform proposals, the American Public Welfare Association has recommended speedy and substantial reform.

To bring order to "an overlapping maze of assistance programs," the association recommended consolidation of programs, including AFDC, food stamps and local general assistance into a single program. Under this proposal, there would be a minimum payment which would be fully funded by the Federal Government. The level of payment would be based on a percentage of the U.S. Government poverty index and updated annually.

Additional recommendations include:

- No recipient should receive a lower payment under a new program than under the current cash assistance program.
- As an incentive to work, employed program participants should continue to receive assistance payments of up to one half the amount they earn.

The association recommended States administer payments because they already have a system which can readily be adapted to the proposed program.

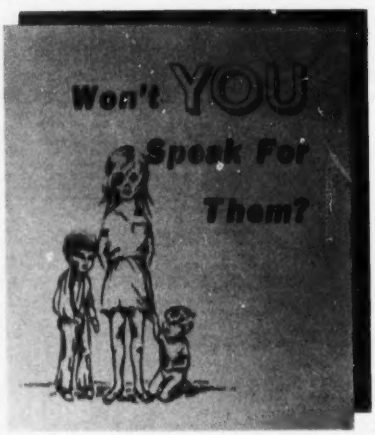
The association is a national nonprofit organization of government agencies, organizations, and individuals concerned about national social policy.

WIN job placements reach record high

The Work Incentive program (WIN) landed more full-time jobs for welfare recipients in the month of June than any other month in the past eight years.

Some 23,680 full-time jobs were filled that month, according to the WIN National Office, the organization which directs the program that helps welfare recipients find jobs and trains them for jobs.

Over half of the jobs were in white-collar and service occupations with an average starting salary of $2.90 per hour.



Prevention campaign launched for child abuse

Following a successful campaign against child abuse and neglect in northern Pennsylvania, the Governor is launching a region-by-region campaign throughout the State.

The keystone of this effort is a toll-free number for reporting suspected child abuse.

Two months after it began operation in March, the program had logged 1,676 reports. Every case was investigated and, according to the Welfare Department, abuse or neglect was confirmed in 45 percent of the cases.

Information and referral service set for pilot phase

Michigan will begin operating a computerized information and referral system by mid-fall on a test basis. Network, as the operation is called, is expected to cope with some four million calls each year from citizens seeking the specific agencies which can help them with their problems.

Public and private agencies, representing a cross-section of local human services will be linked to the computer by terminals like those at airline ticket counters.

This system allows instant information retrieval plus nearly instant updating of the resource file.

If the project is successful, the State hopes to have some 350 terminals installed statewide.

Medicaid fraud unit created by Pennsylvania

A Special Investigations Unit to intensify efforts to track down Medicaid fraud and abuse has been created by the Pennsylvania Department of Public Welfare.

"The new unit will concentrate on flagrant fraud and is not intended to prosecute clients or providers who may have received overpayments through employee error or misunderstanding of the regulations," says Welfare Secretary Frank S. Beale.

The unit, which was created in July, is currently investigating some 130 cases.

During the six-month period before the unit was established the welfare department collected more than $184,600 in restitution from 63 medical providers, and the collection

process was begun on another $195,000 from nine providers.

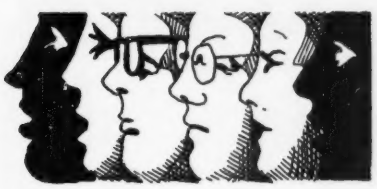
Callers linked to help via toll-free telephones

A toll-free telephone service is providing information about the 47,000 human services offered by more than 5,000 private and public agencies scattered throughout North Carolina.

Since "Careline's" inception 18 months ago it has provided information and referrals for some 39,000 callers.

A staff of 13 operates the system, which includes four telephone lines. Information about agencies is kept up to date by persons who collect information in four regions of the State. The budget for fiscal 1976 was $246,000.

While the system is primarily aimed at providing service for citizens, the department anticipates internal benefits. Says Welfare Secretary Phil Kirk, "We can identify unmet needs from the requests that indicate no resources exist, or we can find if there is duplication or overlapping of programs. This information can be used in planning department programs and shared with private agencies involved in human services."



People

Ray C. Goodwin has been named deputy commissioner of the Virginia Department of Welfare. Prior to the appointment he was chief of the Social Services Division of the Human Resources Department in Arlington County, Va.

Gerald F. Radke has been named Deputy Secretary for Social Services, Pennsylvania Department of Public Welfare. Mr. Radke has served as director, Office of Planning and Evaluation and commissioner, Social and Medical Services of Pennsylvania's Western Region.

Letters to the Editor

Agency uses Mathews views

To the Editor:

I would very much appreciate fifty copies of the article, "Mathews Seeks Partnership With The States," if this is available. We have an Income Maintenance Task Force composed of representatives from throughout the State of Ohio and this article would be helpful.

Joseph D. Gibboney, D.S.W., ACSW
Executive Secretary
Department on Social Concerns
Catholic Council of Ohio

AFDC statistics helpful

To the Editor:

We wish to compliment your carrying of the article entitled, "The Typical Family," by Howard Oberheu in your July - August, 1976 issue of *The Record.*

We would be interested in obtaining reprints of that article in conjunction with our recently developed training program. One module of this training package uses statistics to challenge some welfare myths. We believe Mr. Oberheu's presentation of AFDC family characteristics to be superior.

Please let us know if we could have 500 reprints for our training program.

Richard E. Larson
Department of Social Services
City of Baltimore

To the Editor:

I have read the article "The Typical Family compared with the AFDC Family" in the July/August issue of the *Record.* I believe the article would be extremely helpful to each of Georgia's County Departments of Family and Children Services. If possible, could you provide this Department with 159 copies so I could share the article with each of these departments.

(Mrs.) Betty R. Bellairs
Director
Division of Benefits Payments
Georgia Department of
Human Resources

Can they go home again?

To the Editor:

Please send me all of the available information relating to your article ("Can They Go Home Again") on the La Crosse, Wisconsin Project for the monitoring of the quality of life program for the aged.

Carl V. Granger, M.D.
Professor and Chairman
Department of Physical
and Rehabilitation Medicine
Tufts University

The Record invites notices of top-level appointments and news of State and local activities of interest to other professionals. Contact Patricia Fells, assistant editor.

Subsidized Adoption Is Key to Problem Placements

by Patricia Fells, Assistant Editor

Some children who might never have a home of their own and adults who want to adopt children but are financially unable are being brought together in Tennessee through a subsidized adoption program.

When all efforts to have a child adopted fail, the Department of Human Services finds a family which qualifies to adopt children in all aspects except income level and arranges for supplemental support of the child.

From May 1972 to June of this year, the department has subsidized 45 adoptions, 29 of which were long term. The cost of each has ranged from $35 to $205 per month.

There are three types of subsidies, and a family may receive a combination of them. The subsidies are:

- Payment for attorney's fees and court costs, medical and psychiatric services, special medical equipment, etc. This payment is made as needed.
- Payment for a definite duration to help the family with the initial expense of receiving a new child into its home.
- Long-term monthly payments to the adopting parents to supplement their support of the child. The payment cannot be larger than the amount that would be required for the child's care if he remained under foster care. Such payments continue only until the child reaches age 18, or 21 if he is in school.

"I feel that this program is another major resource in helping us help those with unusual needs," says Horace Bass, commissioner of the Tennessee Department of Human Services. "This program enables us to make good placements both for children and parents we might not otherwise be able to make."

The department accepts applications for subsidized adoptions only from persons who wish to adopt a hard-to-place child.

After an application for adoption has been approved the couple is given a thorough explanation of the difficulties involved. If the child is handicapped, the couple is shown how other children with the same handicap function in day-to-day activities. The couple also receives detailed instructions on the special care the child requires.

After an adoption is finalized, the department continues to monitor the case for a year before the parents are given full responsibility for the child. Aside from the monitoring, the only link then between the department and the family is the monthly payment. However, should an emergency arise, the department is available to help resolve the crisis.

Parents already caring for a child under a foster care arrangement are encouraged to consider adoption under the subsidy program.

An example of the effectiveness of this program is Jamie, a four-year-old who had been labeled "hard to place" because of his seizures, badly bowed legs and slow mental development.

Jamie was placed in a foster home 18 months ago with a couple which has two children of their own and serve as foster parents for the department. In the past eight years they have cared for 22 foster children.

At that time the youngster could speak only a few words and had trouble making his feet and legs do what he wanted them to. After a few months the couple decided they wanted to adopt Jamie but were reluctant to take full responsibility for a handicapped child. They thought that if the county, or church or somebody would help with his medical bills then "they could keep him forever."

The Department of Human Services offered to contribute $100 a month toward Jamie's support and to also pay for any unusual medical treatment if the couple would adopt him.

So far they have not asked for any major medical help. Jamie's medicine seems to be preventing the seizures, and the braces and treatment provided by the Crippled Children Service and therapeutic exercise have helped rehabilitate his legs. As for his mental development, it appears all Jamie needed was someone to answer his questions, and his new mother spends hours at this.

Says his mother about the subsidy program: "I think this is one of the best programs they ever had for children."■

A Brief History of Social Services Part II

The purpose of Government is to do for the people what they cannot do for themselves or cannot do so well for themselves . . .

—Abraham Lincoln, 1854.

When Franklin Delano Roosevelt campaigned for the Presidency in 1932, he called for bold, persistent experimentation. "If it fails," he said, "try something else. Above all, try something. The millions who are in want will not stand by silently forever while the things to satisfy their needs are within easy reach . . ."

To understand the situation is to understand why the President, the Congress and the citizenry were so willing to rush with such boldness in directions most had tried so hard to avoid for years.

The situation in 1932 was this: One out of four workers was unemployed. Since October 1929, between 4,000 and 5,000 banks had failed. Lifetime savings of Americans of all ages,

vocations and economic levels had vanished. Industrial chimneys were smokeless. And thousands upon thousands of elderly persons, who in better times had been cared for by their children or grandchildren, were now in need.

Unemployment, Roosevelt said, was an industrial hazard and one of his first concerns. A second concern was the inevitability of old age and the dignity of older Americans that was diminished by dependency.

The Brookings Institution had reported that the "average" American family in 1932 required $2,000 a year for basic necessities. But even at the peak of prosperity — in 1929 — many families did not have even that. Studies showed that 20 percent of families in the U.S. earned less than $1,000 and another 20 percent earned between $1,000 and $1,500. The farmer's situation was even worse: half the nation's farms produced a gross income of less than $1,000 a year, and there were eight million people living on farms producing less than $600 a year. Agriculture had never recovered from the depression which began in 1920.

The weather, too, dealt its own economic ruin. The Tennessee Valley area — about 40,000 square miles in a multi-State region — was bitterly impoverished by rampaging floods. And a prolonged drought followed by wild, searing winds turned parts of mid-America into what became known as the Dust Bowl. Citizens swallowed dust and watched their farms swirl away.

Emergency reaction

Foreclosures of residential mortgages had become rampant, so in July 1932, the Federal Home Loan Act was passed to prevent foreclosures. And, in the same month, President Hoover authorized the Reconstruction Finance Corporation to lend almost $2 billion to State and local governments to avoid insolvency and to launch what he termed "productive" public works.

But what really began to lift the economy off the launching pad was the New Deal's three Rs — Relief, Recovery and Reform. The plan was this: For the short range, which the new President estimated to be two years, the Administration would concentrate on relief and recovery; the long range goal would be permanent recovery and reform of the kinds of abuses and misjudgments which had caused the boom-to-bust catastrophe.

One of Roosevelt's early major moves (May 1933) was to push for funds for emergency relief. The result was the Federal Emergency Relief Administration capitalized at $500 million. Harry Hopkins, who had submitted a plan to FDR showing the States' inability to provide cash assistance without Federal help, was appointed administrator. Before the end of 1933 he had invested the entire half-billion. Pleased, FDR asked and got an additional $850,000 for the FERA program.

Some FERA money was used to provide jobs on public projects. Roosevelt called them the first step away from the dole and said the goal of public works was to "remove from relief all employable persons . . ."

The press of the day alternately praised the momentum with which the Administration moved forward and condemned it for its astronomical spending and the proliferation of agencies. Washington's favorite dish, it was said, was alphabet soup: CCC, CWA, PWA, WPA, TVA, HOLC, NRA.*

As the emergency relief and make-work programs began to ease poverty and unemployment, the President turned his thoughts toward his real interests — more long range objectives.

In an effort to persuade States to enact unemployment compensation laws, the Wagner-Lewis bill was introduced. But, although it had had strong support from Secretary Frances Perkins and the President himself, it died in committee.

The plan is laid

Perkins and Hopkins argued that unemployment insurance alone was not the answer and the President was impressed. The three agreed that the time was ripe for a broad measure to provide security for citizens in need.

Roosevelt announced his social security plan while the plans themselves were still being formulated. In his special message of June 8, 1934, he said:

"Next winter we may well undertake the great task of furthering the security of the citizen and his family through social insurance.

"This is not an untried experiment. Lessons of experience are available from States, from industries and from many nations of the civilized world. The various types of social insurance are interrelated; and I think it is difficult to attempt to solve them piecemeal. Hence, I am looking for a sound means which I can recommend to provide at once security against several of the great disturbing factors in life — especially those which relate

First steps toward recovery in 1933

March 6	FDR closes banks.
March 9	Emergency Banking Relief Act.
March 31	Civilian Conservation Corps created.
April 5	FDR orders gold surrendered.
April 19	U.S. goes off gold standard.
May 12	Federal Emergency Relief Administration authorized.
May 12	Agricultural Adjustment Act.
May 18	Tennessee Valley Authority Act (TVA)
May 27	Federal Securities Act.
June 5	Gold payment clause repealed.
June 13	Act creating the Home Owners' Loan Corporation.
June 16	National Industrial Recovery Act — creates National Recovery Administration (NRA) and Public Works Administration (PWA).
June 16	Federal Deposit Insurance Corporation created by Glass-Steagell Act.

* Civilian Conservation Corps, Civil Works Administration, Public Works Administration, Works Progress Administration, Tennessee Valley Authority, Home Owners Loan Corporation, National Recovery Administration.

The uncomprehending stare of a child who does not know why he is cold or a little hungry became an increasingly familiar sight as the Great Depression wore on. Though rural families did not have to stand in bread lines, like the one at the Brooklyn Bridge approach, they often went barefoot.

to unemployment and old age. I believe there should be a maximum of cooperation between States and the Federal Government. I believe that the funds necessary to provide this insurance should be raised by contribution rather than by an increase in general taxation. Above all, I am convinced that social insurance should be national in scope, although the several States should meet at least a large portion of the cost of management, leaving to the Federal Government the responsibility of investing, maintaining and safeguarding the funds constituting the necessary insurance reserves.

"I have commenced to make, with the greatest of care, the necessary actuarial and other studies necessary for the formulation of plans for the consideration of the 74th Congress . . ."

Three weeks after his message to Congress, FDR issued an Executive Order creating the Committee on Economic Security to study the social security question.

The blue ribbon committee consisted of the Secretaries of Labor, Treasury and Agriculture, the Attorney General, and the Federal Emergency Relief Administrator. The President's choice for Executive Director was Dr. Edwin E. Witte of the University of Wisconsin, who that summer was the acting director of Wisconsin's Unemployment Compensation Division.

Dr. Witte was notified of his selection by phone on July 24 and arrived in Washington two days later. He was told that he must present a plan for the most sweeping social legislation in history before Christmas. It was decided Dr. Witte's committee should have an Advisory Council on Economic Security "consisting of representatives from various departments and agencies of the Federal Government," and a Technical Board. The Technical Board included committees on Unemployment Insurance, Old Age Security, Public Employment and Relief, and Medical Care. The board was also to make recommendations on security for children. Emphasis on the importance of children was curiously absent.

The objectives of the committee were defined as: (1) a long-time comprehensive program embracing all phases of economic security; and (2) an immediate legislative program confined to issues "palatable" to the Congress.

The committee's report was presented orally to the President on December 24. The crux of the report's concept of economic security was this: "Economic security is a much broader concept than social insurance, embracing all measures to promote recovery and to develop a more stable economic system, as well as assistance to the victims of insecurity and maladjustment. The interrelation of all these various approaches must be kept in mind . . .

"The field of study to which the committee should devote its major attention is that of the protection of the individual against dependency and distress. This includes all forms of social insurance (accident insurance, health insurance, invalidity insurance, unemployment insurance, retirement annuities, survivors' insurance, family endowment, and maternity benefits) and also problems of providing work (or opportunities for self-employment) for the unemployed, and training them for jobs that are likely to become available. These several problems must be studied not only from the point of view of long time policy, but must be related to the present relief and unemployment situation . . ."

In hammering out the written report, there was much heated debate among members of the committee and among members of its advisory board on both major and minor aspects. Compromises were made and the report was submitted to the President. Upon receipt, Roosevelt immediately announced that he would submit a special social security message to Congress. But, shortly thereafter, on January 16, he discovered something in the old age insurance program which he disliked: a notation that a large deficit would develop in the insurance program after 1965, forcing the use of general tax revenues to cover it. The calculations also showed the deficit would increase to a staggering $1.4 billion a year by 1980. The President insisted this section of the proposal must be changed. Accordingly, the recommended tax rates and benefits of the report were downgraded to be merely one alternative which Congress might consider, rather than the prime recommendation of the committee.

The following day, the President sent a special message to Congress accompanied by a draft bill based on the *Report of the Committee on Economic Security*.

He expressed concern that Federal legislation on unemployment compensation "should not foreclose the States from establishing means for inducing industries to establish an even greater stabilization of employment."

When the bill was drafted, the old age assistance segment was put first because of its popularity, thus directing attention away from the less palatable titles.

Fighting for the bill

At first the proposed economic security plan was received with enthusiasm and termed "sound" and "constructive." But as the new year began criticism began to appear and by mid-March it peaked.

Attention was called to earlier dissension among members of the committees and expert consultants. The speed with which the proposal was prepared, critics said, showed lack of thorough consideration. Delay was urged. The omnibus nature of the bill was also criticized as was its draftmanship.

President Roosevelt was adamant. It was the Administration's bill or nothing. Opponents in and out of Congress realized that unless they supported it the nation would not get an economic security program.

When the redrafted legislation got to the House Ways and Means Committee it was called the Economic Security bill. Ways and Means, having received thousands upon thousands of letters of criticism and endless suggestions, itself rewrote the legislation and changed the name of the bill to the Social Security Bill. The

House debated it for more than a week, during which time more than 50 amendments were offered (but none adopted). The House passed it on April 19.

In the Senate there was also controversy over the compulsory old age insurance and voluntary annuity provisions.

The House version of the bill was not completely satisfactory to the Committee on Economic Security. During testimony before the Senate Finance Committee, CES Chairman Perkins recommended restoring to the States the right to:

- Have either an individual employer account or a pooled-fund type of unemployment insurance.
- Put the Social Security Board in the Department of Labor.
- Make retirement from regular employment a condition of receiving old age pensions.
- Place administration of Aid to Dependent Children in the Children's Bureau (it was then in the Department of Labor).

The Senate committee approved the first three recommendations, but did not go along with the proposal that the Children's Bureau administer Aid to Dependent Children. (It was ultimately placed under the umbrella of the Social Security Board, eventually to become an independent agency.)

Aid to Dependent Children

If old age assistance was at the top of the political barrel, Aid to Dependent Children was certainly at the bottom. This was in spite of the fact that one of FDR's goals was that children should not be deprived because of the inadequacies or absence of a parent.

Before the House Ways and Means Committee had rewritten the original bill, there was no limitation on Federal grants for ADC except that the amount would not exceed one-third of that spent by State and local governments. In Ways and Means executive sessions, however, the decision was made to limit ADC (termed "mothers' pensions") to the maximum amount paid to children of servicemen killed in action in World War I — $18 a month for the first child and $12 for each additional child.* Overlooked was the fact that the Veterans' Pension Act also provided $30 a month for the widow.

Dr. Witte was shocked. He told the Ways and Means Committee that, in many instances, the proposal would reduce Federal aid for children to less than a third of the States' current expenditures. It was totally illogical, he insisted, "to expect a mother with a child under 16 to live on $18 a month when old age assistance grants of $30 per month per person were contemplated in the same act . . ." The criticism was acknowledged as valid, but no effort was made to strike the restriction.

"There was little interest in Congress," Dr. Witte recorded in his diary, "in the aid to dependent children. It is my belief that nothing would have been done on this subject if it had not been included in the (committee's) report . . ."

Maternal and child health services and child welfare services were other major concerns of the Children's Bureau. Although recommendations for aid in the health field were opposed (mildly) by organized medicine and welfare services by the Catholic Church (which feared a Federal invasion of the domain of private welfare agencies), both measures had the support of leading women's organizations and citizens' groups.

The section on child welfare was modified to the satisfaction of the Catholic Church to read ". . . public welfare services (hereinafter . . . referred to as 'child-welfare services') for the protection and care of homeless, dependent, and neglected children, and children in danger of becoming delinquent." In addition, child welfare work was to be emphasized in predominantly rural areas where there was a scarcity of private social service agencies.

Aid to States for crippled children, also recommended by the Children's Bureau, received little opposition. Groups like the Masons were doing notable work in the field but agreed that Federal participation would be valuable and would encourage the States to develop more comprehensive services.

Child welfare services were combined with ADC in Title IV of the Social Security Bill while Maternal and Child Health and Crippled Childrens' aid were placed in Title V.

Medical services

The bill authorized $2 million for the Public Health Service to expand its staff and $8 million for the States to develop and expand State and local health services. There were no provisions in the bill for health insurance, a subject which received only brief mention in the committee's report. The committee had, however, given serious attention to the question believing that no comprehensive program of social insurance/security could logically omit insurance against the costs of illness.

The fact that health insurance was omitted reflects the desire of the Administration to avoid hostility from the medical profession. An editorial in *The Journal of the American Medical Association* that year accused the Administration of trying to "railroad health insurance through Congress, without as much as consulting the profession." Similar comments were made in State medical journals.

After the committee's Medical Advisory Committee succeeded in establishing cordial relations with the AMA, the association reversed its earlier position of complete opposition and endorsed experimentation with voluntary plans under the control of State and county medical associations. But, Dr. Witte recorded, "it (AMA) strongly condemned compulsory health insurance and all forms of lay control of medicine." Medical assistance for the aged, however, remained in combination with cash assistance (Old Age Assistance) in Title I of the bill.

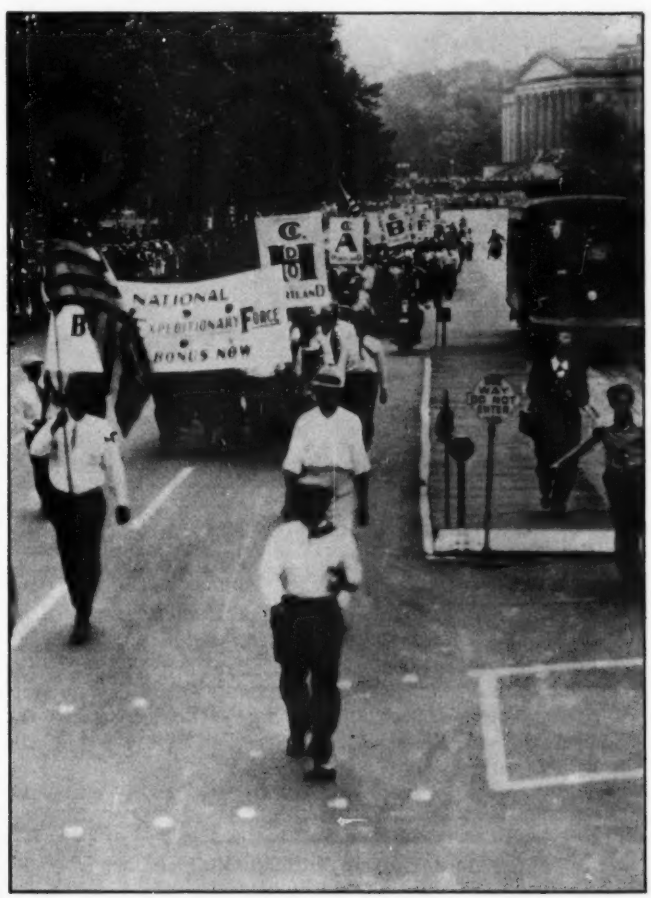
Old age insurance

Efforts were made to carve out the old age provisions and submit them as a separate bill. Old age legislation was further complicated by hearings and debate on the Townsend Plan, a proposal that the Federal Govern-

* In effect, this meant that the Federal share (regardless of the amount of the State's grant to the children) would be only six dollars for the first child, and four dollars for each additional child, i.e. one-third of $18 plus one-third of $12.

Waiting for commodities outside a relief station in Urbana, Ohio in 1938.

The Bonus Army marches on Washington in 1932.



ment give every person 65 years or over $200 a month, provided that that amount was spent during the month received. An alternate plan was Huey Long's "share the wealth" proposal for a one-time handout of $5,000 to every family and $2,000 a year thereafter. The money would come from heavier taxes on the rich.

Aid for the blind

When the Economic Security Bill was introduced, several groups — including the American Foundation for the Blind — came forward for the first time and recommended Federal aid to the States for field work for the blind. Helen Keller proposed that States be authorized to use half of any Federal appropriation for the blind to expand field services, with the remainder to be used for assistance to blind persons themselves.

The Senate went along with this idea, but when it came to a House-Senate conference, members of both houses took the position that field work meant "merely increased employment for social workers." So aid to the blind was limited to Federal funds for States to create pensions for the blind similar to old age pensions.

The House accepted the conference report on August 8, 1935, the Senate the following day. The President signed the Social Security Act on August 14, 1935, thus inaugurating the most significant change in the structure of the U.S. economy in the nation's history.

In the 41 years since the Social Security Act became law, it has been amended numberless times. Volumes have been published about it. It has been condemned and praised. An attempt was made, unsuccessfully, to declare it unconstitutional. There have been rumors that the trust fund established by the act can not carry the cost of benefits to the rapidly increasing number of beneficiaries.

But the act has not only remained intact, its original 10 titles have been increased to 20, extending benefits from 24 million persons in 1939 to 68.1 by 1971.

Part III of this series, "The Federal-State Partnership" will appear next month.

Like Mother Like Daughter

Mommy beat up daughter. Now daughter is beating up dolly. It's so easy for a child abuser to create another generation of child abusers.

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For a free supply of this poster write: Editor, The Social and Rehabilitation Record, Rm. 5327 SRS/HEW, Washington, D.C. 20201

Publications and Films

Please address all inquiries and requests to the addresses in the listings.

Publications

Schools of Social Work with Accredited Master's Degree Programs. July 1976. Council on Social Work Education, 345 E. 46th St., N.Y., N.Y. 10017.

This brochure lists schools in the U.S. and Canada and includes those offering post-master's programs and new schools working toward accreditation.

Long Term Care: A Handbook for Researchers, Planners, and Providers. Sylvia Sherwood, editor. Spectrum Publications, a division of Halsted Press, 605 Third Ave., New York. 10016. $25.

This volume concentrates on the care provided to adults. The target population encompasses the chronically ill and disabled adults who either reside in institutions or may be considered at risk or potentially at risk of institutionalization.

The total person is considered. Questions are directed toward the physical, social and psychological functioning of the individual, the quality of care, and the options available, particularly in the form of alternatives or options available in long-term care.

The volume is divided into contexts, perspectives and issues. A historical analysis of long-term care institutions is presented as a basis for developing future research and services.

The issues cover such topics as the family as a resource in chronic illness and alternatives in long-term care to evaluation instruments in long-term care and strategies for research and innovations.

The appendix contains a list of published materials on long-term care prepared by or available from the Federal Government.

Unemployment: The Problem We Can Solve. Andrew Levison. Public Affairs Committee, 381 Park Ave., South, New York 10016. 35 cents.

This booklet discusses the meaning of unemployment, who is unemployed, and the extent of the unemployment problem. It surveys methods tried in the past to provide jobs, and looks at French and Swedish employment policies for clues to assuring full employment for Americans.

The following three-volume series **Child Abuse and Neglect** is available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D. C. 20402.

Volume 1, **An Overview of the Problem** ($1.50), discusses child maltreatment, including characteristics of the parents and children, effects of abuse and neglect, a psychiatrist's view of the problem and a discussion of State reporting laws. It also examines problems of definition and incidence of deficiencies within our system of child protection.

Volume 2, **The Roles and Responsibilities of Professionals** ($1.90), discusses the roles of those working with abusive parents, child protective service agencies, physicians and hospitals, the police, teachers and the schools.

Volume 3, **The Community Team: An Approach to Case Management and Prevention** ($2.60), presents the community team approach to identification and diagnosis, treatment, and education. It includes suggestions for developing a coordinated community program, examples of existing programs, and some ideas on the prevention of child abuse and neglect.

General Assistance in Michigan: A Profile of Program and Recipient Characteristics. Michigan Department of Social Services, Lansing, Michigan 48926. Publication No. 259 (7/75) $5.

General assistance is a locally administered welfare program financed by State and county funds which serves the needs of individuals and families who require public assistance but do not qualify for either Aid to Families with Dependent Children or Supplemental Security Income.

This study concludes that general assistance is inadequate and inequitable. It is inadequate when compared to categorical assistance because average total requirements for singles and families were 24 and 32 percent, respectively, below the comparable categorical average total requirements.

Inequities exist among county general assistance programs and between general assistance as a whole and categorical assistance. Similar general assistance recipients in different counties were rarely treated the same, and general assistance cases were not budgeted for as much as similar categorical assistance cases.

Day Care: Problems, Process, Prospects, a special issue of *Child Care Quarterly.* Donald L. Peters, Editor. Human Sciences Press, a division of Behavioral Publications, Inc., 72 Fifth Avenue, New York 10011. Hard, $9.95, No. 279-4; Paper, $3.95, No. 290-5.

This volume focuses on current issues in the day care field in the United States and Canada. The contributors provide a balance between theory and practice by clarifying recurring problems and making a variety of specific suggestions for meeting the challenge of providing quality care for large numbers of children.

The articles address such topics as: recurring problems for day care providers, licensing representatives, teachers and parents; training and certification issues; procedures for meeting the individual educational/developmental needs of children; the rationale for and process of involving parents in day care; and research studies for assessment and improvement of every day practice.

International Child Welfare Review published by The International Union for Child Welfare, Rue de Varembe 1, 1211 Geneva 20.

The *Review* provides information for the continuous training of those concerned with children, youth, parents and social action. This journal includes a worldwide look at developments in the social field and lists principal international meetings on children and youth. It is published quarterly in English, French and Spanish.

Films

Just Be Patient. Color. Sound narration. 20 min. Focus International, Inc., 505 West End Ave., New York, N.Y. 10024. Preview fee: $25. Sale: $325.

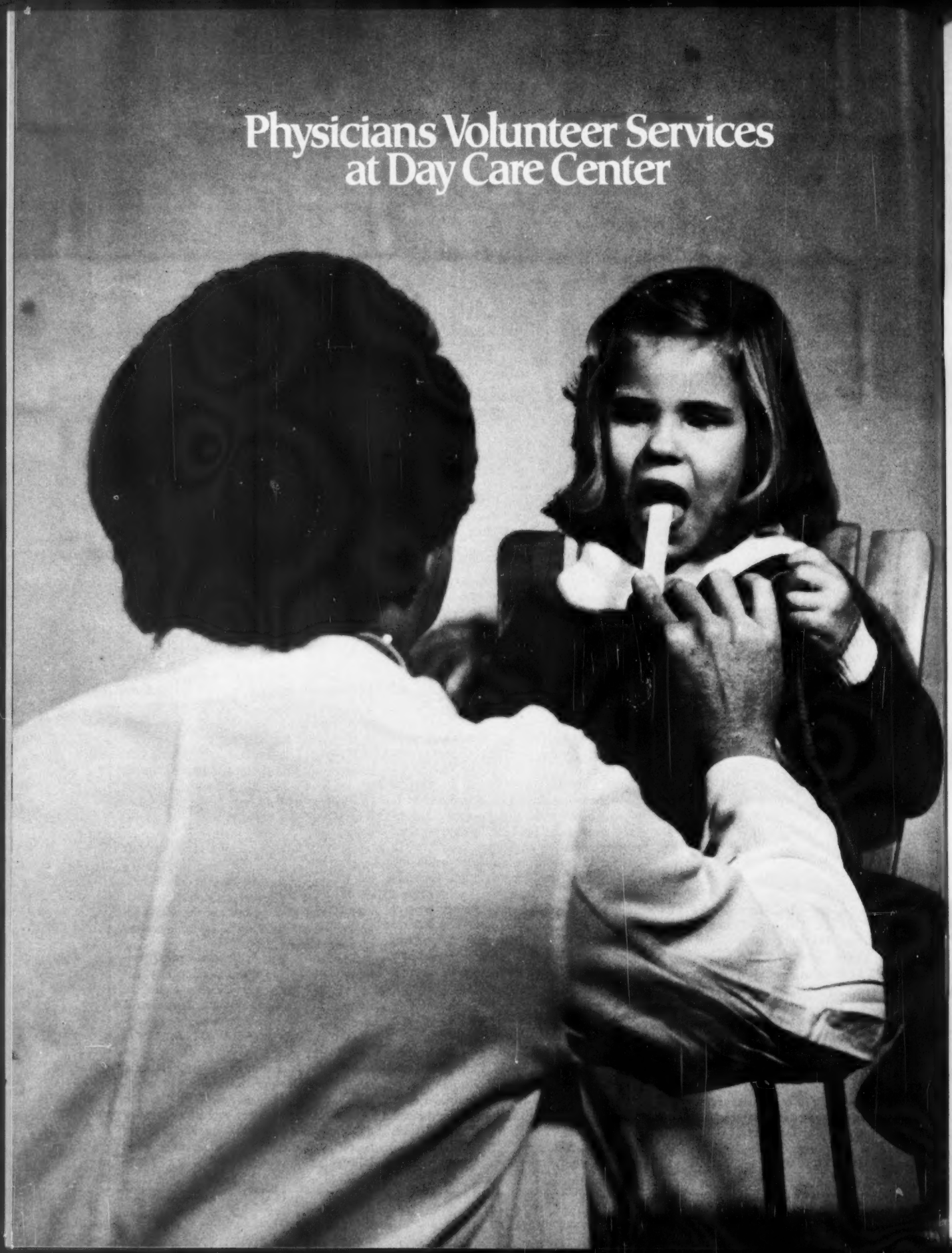
This film is a hospital staff training film designed specifically for use in departments of in-service training, social services, patient counseling, nursing, paraprofessional staff training, pre-med training, and for physicians.

The film follows actual patients through their total hospital experience, from intake and testing, to treatment, recuperation, and discharge—and focuses on their anxiety, confusion, and the fear that can develop from interaction with the hospital environment and staff procedures.

By concentrating on the subtle, often overlooked environmental and interpersonal cues that can evoke anxiety and fear in patients, the film attempts to direct staff attention towards alleviating these problems through simple attention to their own words and reactions to patients.

The film is accompanied by a practical *Guide for Study and Discussion* which outlines training strategies, mainly by the case method. It also includes suggestions on how the film may be profitably used by different hospital departments for staff orientation and in-service education.

Physicians Volunteer Services at Day Care Center



By Barbara Campbell

Physicians have traditionally given their time and skills to care for those who could not afford it, and this article reprinted from The New York Times *illustrates that at least some of today's physicians are continuing this practice. Although we have a nationwide program underway to bring quality health care to children and youth who are eligible for Medicaid, that program is not designed to reach all who might be in need of treatment. Volunteer efforts such as the one described in this article would help bring health care to many more children in need of health care. Hopefully, physicians in other areas will be encouraged to volunteer their services for treating children in day care centers for whom health care is not otherwise available.* — Keith Weikel, Commissioner, Medical Services Administration

Several parents and their children wait outside the little medical office at one end of the large Nevins Day Care Center in Brooklyn.

They cannot believe their luck, some of the parents say. They never thought that their children could have private pediatric care because most of them—veterans of the long-wait-different-doctor syndrome of clinic care—cannot afford such care.

But once a week Dr. Geoffrey P. Stein, 32 years old, hurries into the large, city-run day-care center on the second floor of 460 Atlantic Avenue, interrupting his busy schedule as chief resident at the Long Island College Hospital, and briskly sets up shop. He has detailed histories of each of his little patients, his medical tools and, last but not the least important to his 2-to-5-year-old patients, a basket of oatmeal cookies.

Dr. Stein, who admits he is always somewhat behind schedule, says two years ago he volunteered—without pay from either the hospital or the center—to be the children's pediatrician because he believes "good health care is a basic human right."

This day, Dr. Stein must see all of the patients himself. His associate Dr. Yalamanchi Rao, has suddenly become ill. Usually the two doctors check an average of 20 children from 2 to 5 in the afternoon.

As the children come in — some accompanied by their parents, others brought from their classes by members of the staff — the doctor, greets them by name and they laugh at his jokes or, depending on their moods, stubbornly refuse to speak.

None of the children who have seen him before are afraid as he examines their ears with lighted instruments, strikes their knees with a little rubber mallet or palpates their abdomens ("You've got a beautiful tummy, do you know that?" he asks one 3-year-old-girl).

And this lack of apprehension, in the opinion of Jo Gross, the director of the center, which takes care of 128 children, is an important change in the attitude that most of the children have toward doctors.

"Most of Geoffrey's work is undoing the trauma that these kids have suffered," she says. "They were terrified of doctors, of needles. They went to clinics and they had the horrendous experience of seeing a different face every time and never getting to know the doctor."

The Board of Health provides doctors for city-run day-care centers, Miss Gross says, but on a much less frequent and sometimes erratic basis.

"For us, this volunteer program works out very well," she adds. "The doctors have a very personal relationship with the children, their parents and the staff."

Miss Gross says she started thinking about a different kind of health program for the center two years ago after the last Board of Health doctor had left.

Dr. Stein and she had mutual friends, and one night, as Dr. Stein remembers it, "we were all sitting around, talking about health-care needs in this area and we thought, why don't we try to start a volunteer pediatric program at Nevins?"

Dr. Stein brought the proposal to the head of his department at Long Island College Hospital, Dr. Joseph R. Bongiorno. "He liked the idea of an outreach program into the community." Dr. Stein said.

After the program was approved by the hospital's board of regents, "these two guys wearing jeans showed up," said Miss Gross. "They really wanted to get involved with the community and the children and the center. You can't beat that kind of care."

Dr. Stein said that, although he did not have "any model to go by," he wanted to be more than "just a needle-pusher" at the center. "We wanted to give good primary health care," he said.

One of the first steps, he said, was to devise an extensive case-history form that he fills out on a child's first visit. He asks for information that is intended to pick up subtle nuances of a child's health record as well as other information concerning the child's developmental history. "You can pick up a lot of things by finding out how the child was delivered, for instance," Dr. Stein said.

About 50 percent of the children are black, 40 percent are Puerto Rican and 10 percent are white. Most come from low-income families, and, Dr. Stein says, many have not had adequate medical care.

"We had a child labeled as a very slow learner," Dr. Stein said, when asked to illustrate why he felt it was important for children at Nevins to get consistent pediatric care. "It turned out that she had an 80 percent hearing loss."

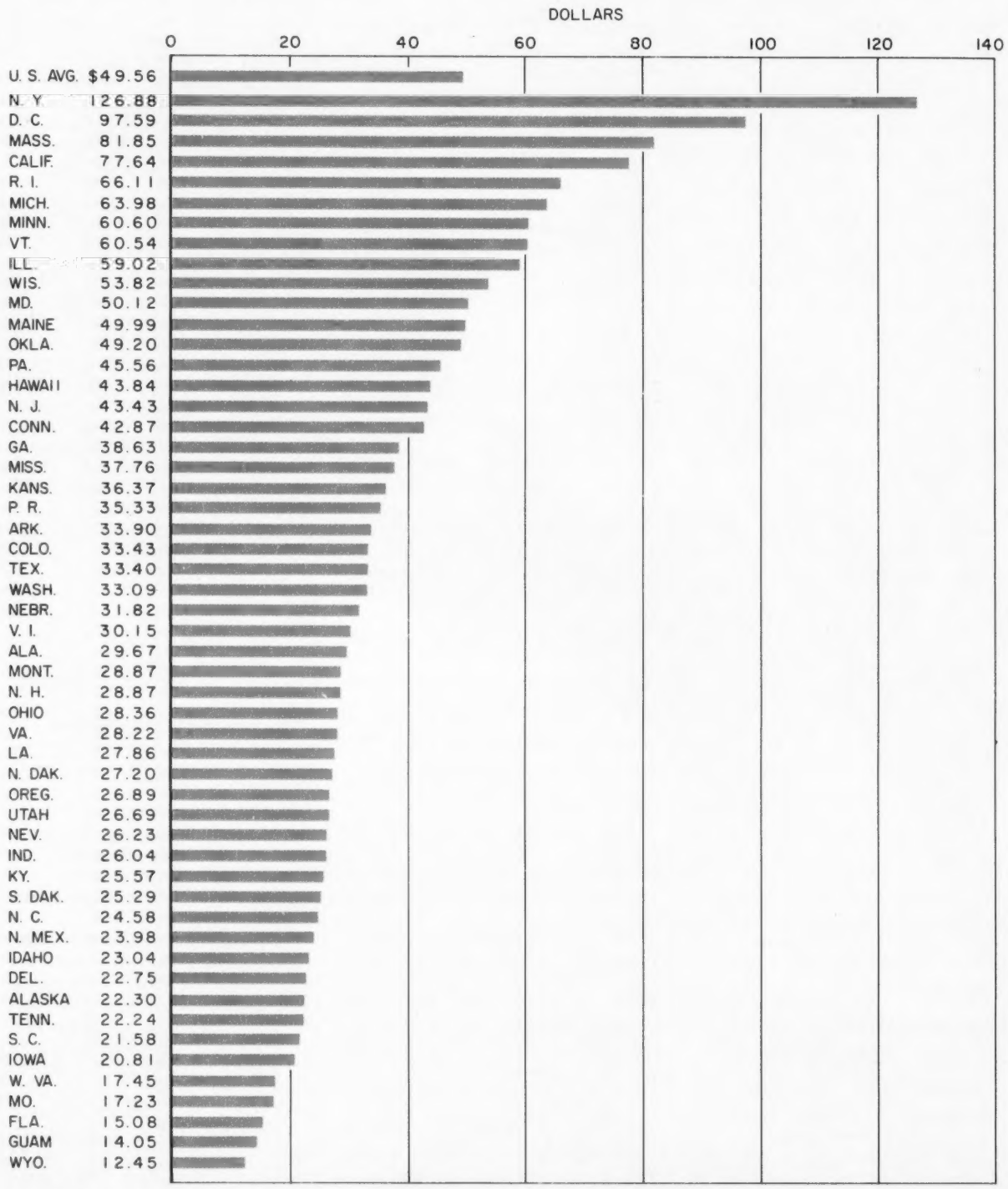
"We took her to my apartment and put earphones on her, and when we turned up the amplifier, her face lit up."

Careful monitoring of the children and his being in the day-care center with them, Dr. Stein said, enable him to note many health problems that might not be evident in another, less-intimate setting.

Dr. Stein says he believes in community-based medicine — in being completely involved with the people he serves. And, he says, he hopes that other teaching hospitals, like his own, will set up similar outreach programs.

"I guess it seems like a poor answer to say I just thought it was a good thing to do to volunteer to come here," he says, "but that's my answer. I guess also it's an altruistic thing to do, too, because it's a pretty good reward for me to know that I have made conditions better for these children."■

Per Capita Expenditures for Medicaid in Fiscal Year 1974



Source: Based on expenditures reported and estimates of the resident civilian population as of January 1, 1974, by the Bureau of the Census

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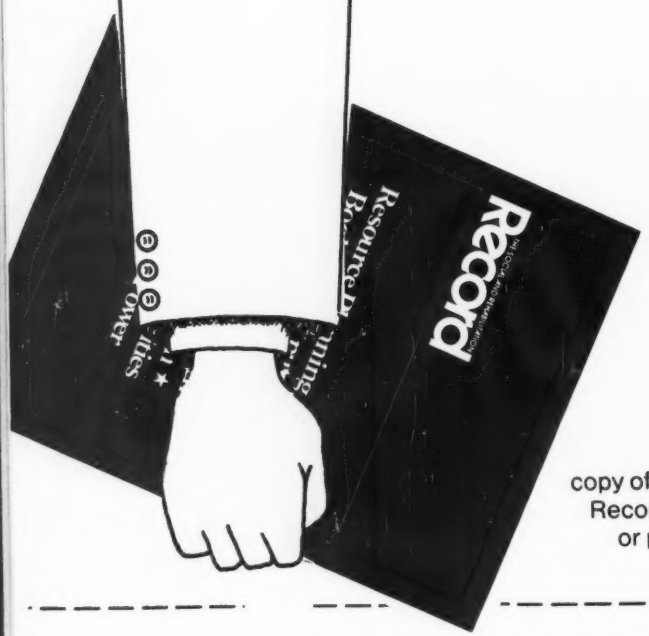

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